BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **PAUL R. MAZZARELLA, M.D.** Holder of License No. **18157** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0761A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 7, 2007. Paul R. Mazzarella, M.D., ("Respondent") appeared before the Board with legal counsel Stephen W. Myers, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 18157 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0761A after receiving information from another regulatory board that Respondent did not respond to a subpoena for records concerning his patient "LM", who is a nurse and Respondent's wife. Respondent and LM dated beginning in 1993 and she became a patient in 1994. Pharmacy surveys revealed Respondent prescribed almost 80 controlled and non-controlled medications to LM between July 2002 and June 2006. In his first response to the Board's notice and request for all medical records for LM Respondent provided a one page progress note from April 2004 and a copy of their marriage certificate. Board Staff thereafter invited Respondent for an investigative interview during which Respondent admitted he prescribed medication to LM, but denied prescribing controlled substances.

Respondent informed Staff the progress note he had supplied was from his own personal file and there were additional records at his previous employer "SMC".

4. Board Staff found Respondent evasive during his interview. For instance, when asked whether it was his signature on the prescriptions written for his wife, he stated he was "not saying that that's [his] signature at this point in time." Respondent was invited for a second investigative interview to clarify his answers to questions regarding his signature on the prescriptions. During this interview Respondent admitted it was a prescription written on his prescription pad and had his name on it but stated "I do not believe it is my signature. I don't know. I mean, they look like my P's, but I have to say I do not think that is my signature really. Definitely, I would say no. They do not look like my signatures even though they are my name. Of course, I cannot speak for these things."

5. The SMC office where Respondent was employed is now closed. Therefore, Board Staff issued a subpoena to another related facility. Although SMC initially stated it was unable to locate LM's file, the Board subsequently received another one-page progress note dated December 21, 2001. Respondent provided additional records from SMC containing progress notes and lab work. The records reveal Respondent saw LM six times over a ten-year period. The records do not contain liver function tests or creatinine following one year of prescribing Lipitor and Enalaperil. The records indicate forty-six prescriptions written between April 2004 and June 2006, but the only available office notes are from April 6, 2004 and June 6, 2004. In supplemental material provided by Respondent is a record of an office visit on June 26, 1997.

6. According to Respondent LM was seen at SMC clinics over the years by numerous physicians or physician assistants as well as by himself. Respondent maintained he properly monitored LM's prescriptions with the appropriate lab work, but those records are not available and that the only controlled medications he prescribed to LM were prescribed before marriage and any prescription after that time attributed to him was not authorized by him.

7. LM became Respondent's patient in August 1994 when he performed a preoperative physical on her. After marriage Respondent continued to be LM's physician for some things, but she also saw numerous other physicians and specialists. Respondent is basically her general physician – treating flu or cold, etc. When Respondent saw LM he did not always write his records in the office. Sometimes if he prescribed an antibiotic or a follow-up renewal medication he would make a mental note.

8. The Board's records contain a prescription for Vicodin dated in March 2005 after Respondent and LM were married. Respondent maintained he did not call in this prescription and that it was probably called in by LM herself. Since the issue of prescribing to a family member arose, Respondent has not looked up the applicable law and, other than information from his attorney, cannot say he is very familiar with the laws. In treating a family member there is a risk that a physician may not be objective and may be biased. At the time Respondent was treating LM he did not see anything wrong with treating a family member as long as he was providing good, appropriate care and he did not see anything ethically or morally wrong with that.

9. During the investigative interview with staff Respondent said he stopped working as an employee of SMC sometime in 2001 or 2002 and thereafter became an independent contractor as a consultant. Respondent could not produce records from 2002 forward and the prescriptions for LM are through 2005.

10. In the last five years Respondent has written prescriptions for his wife but did not keep medical records documenting any prescriptions, any ordered lab work, and any follow-up monitoring for his care of LM because many of the prescriptions were refills, and short of what might be available in SMC's records such as a medication sheet, he did not have records he kept personally. Respondent also does not have records because LM is off some of the medications and he believes he does not need to do the monitoring because other doctors are now doing that. Respondent does, however, continue to authorize medication renewals for LM. When

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Respondent authorizes refills for LM or other friends or family members he does not necessarily write it in a chart that he keeps at home because he knows the pharmacy keeps a good database of refills. Respondent did not keep a record of renewals because he was renewing prior medications initially prescribed by other physicians. Respondent could only assume LM's physicians would know about the refill because he assumed she would tell them. Respondent had no record of any refills/renewals he authorized since 2005.

11. The Board's record contains a March 19, 2006 prescription for Ciprofloxacin, 500 milligram tablets. Although LM had been on this medication in the past, this was a new prescription and Respondent has no medical record to verify the reason for the prescription. The record contains a June 4, 2006 prescription for prochlorperazine. Respondent considered this prescription a refill because LM had been on it in the past. Again, Respondent does not have a medical record that corresponds to the prescription. Respondent wrote a total of twelve prescriptions for LM in 2006 for which he does not have a corresponding medical record.

12. The standard of care required Respondent to review LM's medical records prior to prescribing renewals of medications and to perform appropriate physical examinations and order the appropriate laboratory studies or consultations to follow-up on the patient's status in relation to medications he renewed and not rely on the patient's history or his personal knowledge that she had been on these medications previously.

13. Respondent deviated from the standard of care by not reviewing LM's medical records prior to prescribing renewals or medications and by not performing appropriate physical examinations and ordering the appropriate laboratory studies or consultations to follow-up on the patient's status in relation to medications he renewed and by relying on the patient's history or his personal knowledge that she had been on these medications previously.

14. Without access to LM's records, Respondent could have renewed a prescription resulting in adverse health effects to LM. Without documentation of Respondent's prescribing,

another treating physician could have prescribed a medication resulting in adverse health effects to LM.

15. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent did not maintain medical records for LM, at a minimum, for the period of 2005 to the present.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failing or refusing to maintain adequate medical records and prescribing medications without appropriate physical examination, laboratory studies and documented follow-up.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of August 2007.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of August, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 10th day of August, 2007, to:

Stephen Myers
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Paul R. Mazzarella, M.D.
Address of Record